Policy and Practice: A CMS Update

Presentation to the California Medical Association

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Objectives

- **Identify elements of the CMS National Quality Strategy** and Strategic Pillars guiding agency action

- **Understand the basics of recently announced CMMI models** supporting integrated and coordinated care
  - GUIDE model
  - AHEAD model

- **Describe key reimbursement policies for calendar year 2024** as finalized in the Physician Fee Schedule Final Rule
  - Behavioral Health, MDPP, Dental Health
  - Telehealth, Caregiver Training, Care Integration
  - Quality Payment Program

- **Resources & Questions**

CMS National Quality Strategy

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy

CMS Strategic Pillars

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

https://www.cms.gov/cms-strategic-plan

https://www.cms.gov/sites/default/files/2022-04/13_CCI%20Fact_sheet_4_12%20Final-508.pdf

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PILLAR: HEALTH EQUITY

CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.

CMS is working to advance health equity in three critical ways:

- Designing, implementing, and operationalizing policies and programs that support the health of all the people CMS serves.
- Eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved.
- Providing the care and support that our enrollees need to thrive.

https://www.cms.gov/blog/establishing-framework-health-equity-cms

https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf

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CMMI Model Updates

Innovation Center Strategic Refresh

Created for the purpose of developing and testing **innovative health care payment** and **service delivery models** within Medicare, Medicaid, and CHIP programs nationwide.

Innovation Center Priorities and Strategic Refresh

For more information, the Innovation Center Strategic Refresh White Paper is available on the CMS website.

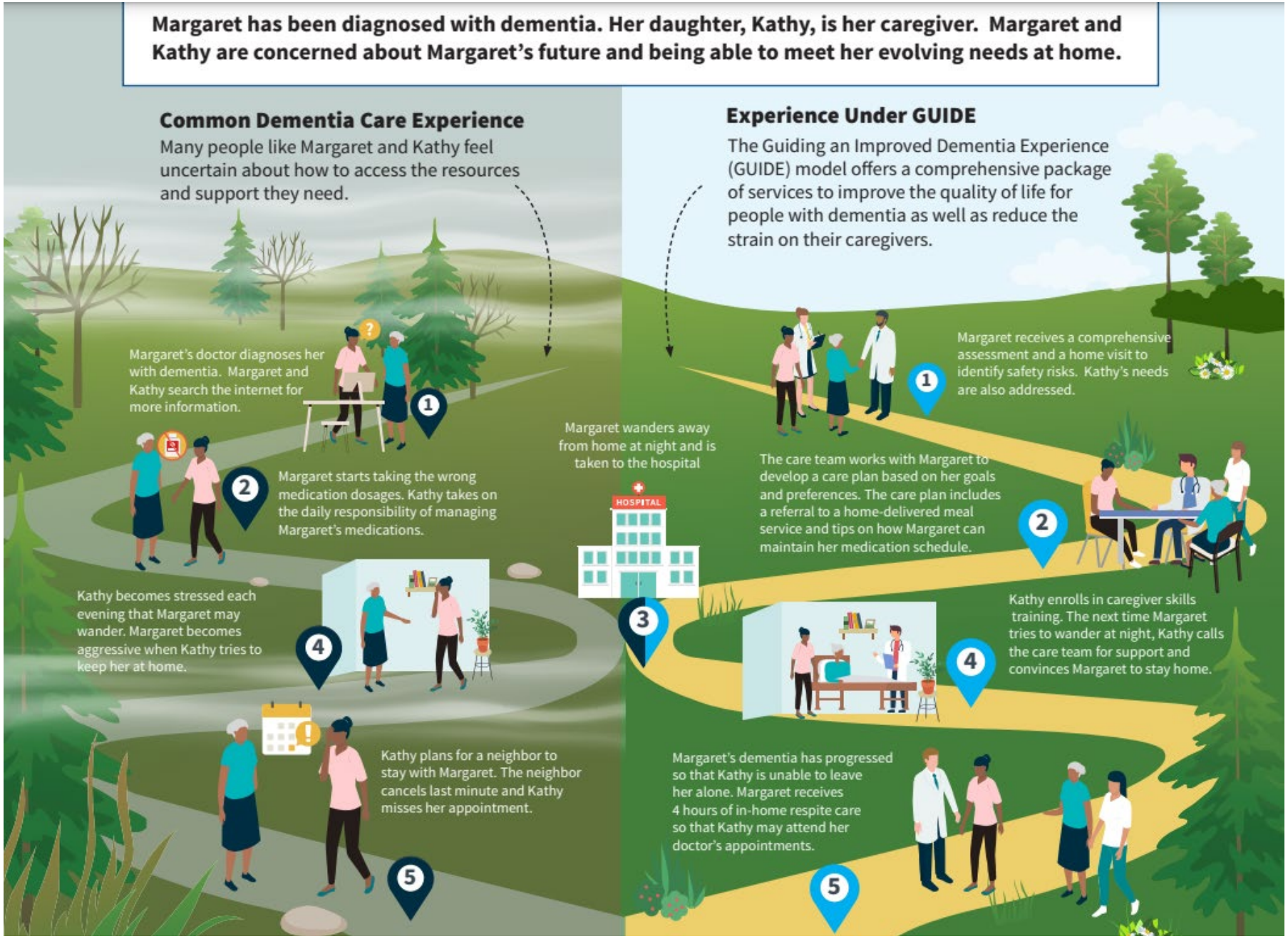
CMS defines health equity as: The attainment of the highest level of health **for all people**, where everyone has a **fair and just opportunity** to **attain their optimal health** regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

https://www.cms.gov/priorities/innovation/overview

The GUIDE Model

Guiding an Improved Dementia Experience

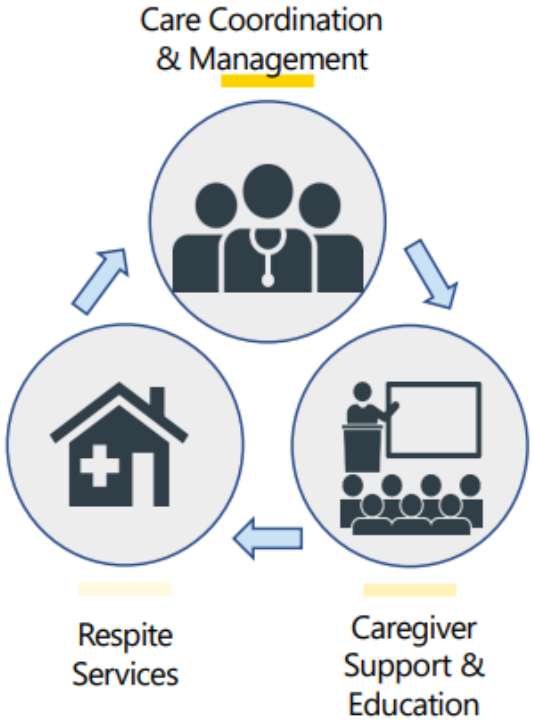
https://www.cms.gov/priorities/innovation/innovation-models/guide



The GUIDE Model

Model Purpose and Overview

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

https://www.cms.gov/priorities/innovation/innovation-models/guide

Example Beneficiary Persona

The GUIDE Model

Margaret Smith

Situation: Margaret, 82, was diagnosed with Alzheimer's disease by her primary care physician (PCP) two years ago. She now experiences moderate symptoms. Her daughter, Kathy, visits her daily at her home but is unable to provide the increased level of attention she now requires. Margaret is unsure how to access support, and her PCP is not equipped to provide the necessary guidance.

Key Information

Location: Atlanta, Georgia

Family: 2 children, 4 grandchildren

Medical Utilizations in Last Year: 1 Emergency Department visit followed by post-acute care at home

Income: $1,700 per month

Margaret's Needs

- Culturally competent, coordinated care.
- Financial support for out-of-pocket medical costs.
- Support for household and personal tasks, such as cooking, cleaning, bathing, and maintaining a medication schedule.
- Assistance with light activity, such as short walks or physical therapy.

Margaret's Challenges

- Lack of savings for in-home care services and medical costs.
- Suffers from sundowning every evening and often forgets to take medications on time.
- Lives alone in a home with steps, which have caused 2 falls in the last 6 months.
- Struggles with Type 2 Diabetes and impaired vision that limits her ability to drive a vehicle.

Margaret's Experience in the GUIDE Model

Comprehensive Assessment and Care Plan

Margaret receives a comprehensive assessment and develops a care plan with her care team, which addresses her safety walking down stairs.

Ongoing Monitoring and Support

Care navigator checks in with Margaret monthly. Kathy also calls care navigator for suggestions on how to cope with sundowning.

Medication Management

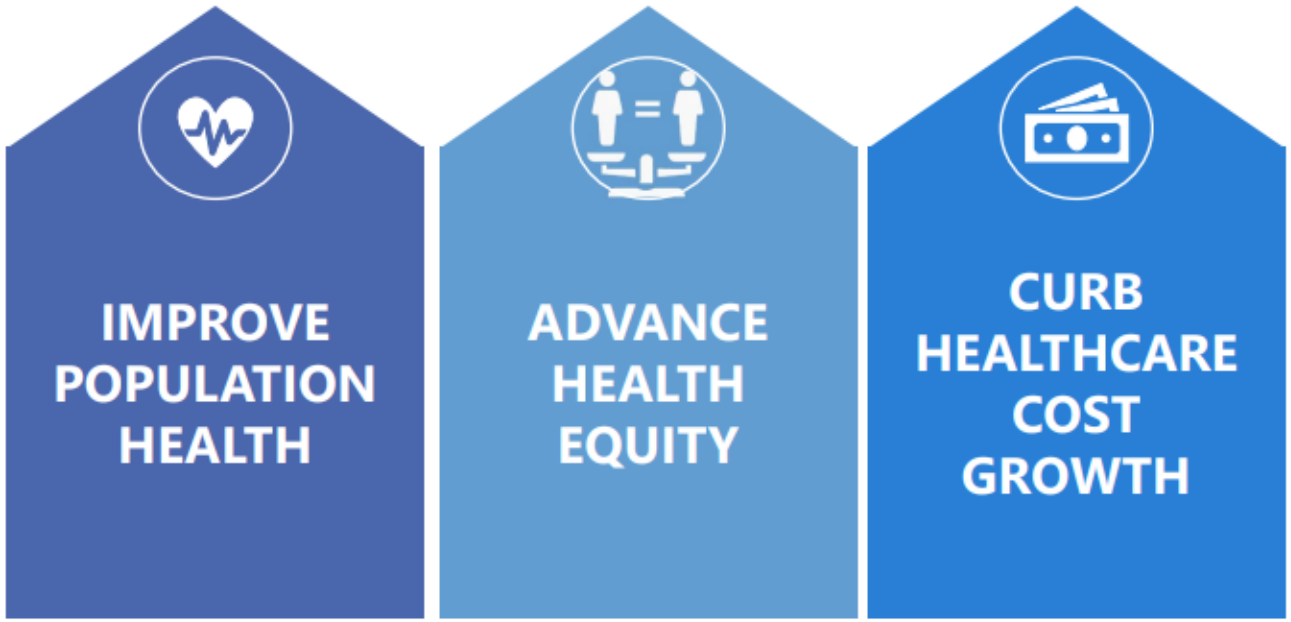
Margaret's care navigator provides tips for Margaret to maintain her correct medication schedule.

Referral and Coordination

Care navigator refers Margaret to a community-based organization that helps her identify service providers.

States Advancing All-Payer Health Equity Approaches and Development

CMS's goal in the AHEAD Model is to collaborate with states to improve population health; advance health equity by reducing disparities in health outcomes; and curb health care cost growth.

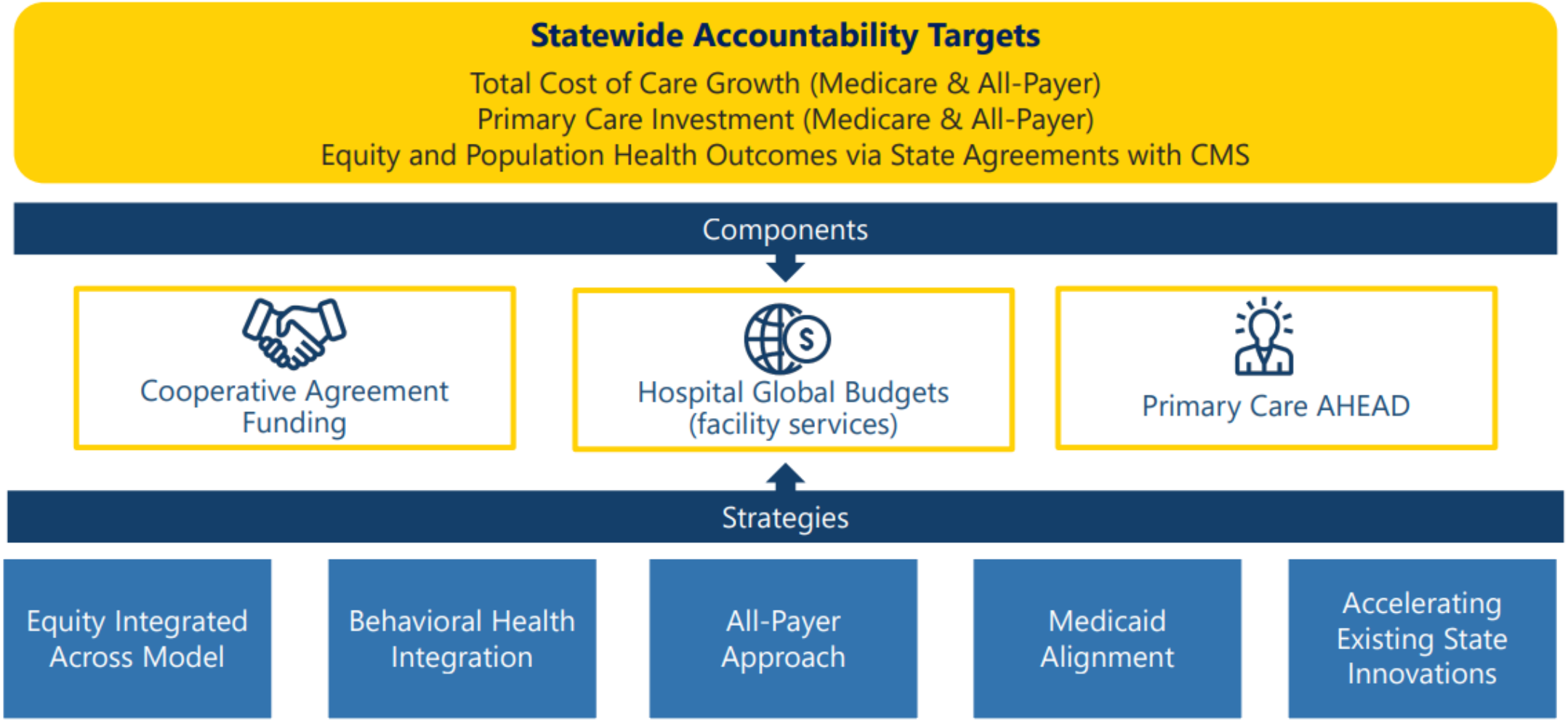


CMS will support participating states through various AHEAD Model components that aim to increase investment in primary care, provide financial stability for hospitals, and support beneficiary connections to community resources.

https://www.cms.gov/priorities/innovation/innovation-models/ahead

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.



https://www.cms.gov/priorities/innovation/innovation-models/ahead

2024 Physician Fee Schedule

Some of the topics covered in the final rule include:

- CY 2024 PFS Rate-setting and Conversion Factor
- Evaluation and Management Services
- Behavioral Health Services
- Dental and Oral Health Services
- Telehealth Services
- Caregiver Training Services
- Social Determinations of Health (SDOH) Risk Assessment
- Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

Rate-setting and Conversion Factor

- The PFS conversion factor is the number that translates RVUs into dollars.

- The Social Security Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million; if they do, CMS applies a budget neutrality adjustment. For CY 2024, the budget neutrality adjustment is -2.18 percent.

- Approximately 90% of the overall PFS budget neutrality adjustment is attributable to the proposal to implement a separate add-on payment for HCPCS code G2211. The remaining 10% is associated with other proposed changes in valuation of codes along with the third year of the clinical labor pricing update. We note that the clinical labor pricing update is responsible for significant shifting of spending between specialties, however these changes are reflected in changes to the RVUs for individual services and do not affect the conversion factor.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

Rate-setting and Conversion Factor (2)

- We finalized a proposal to update the clinical labor rates for CY 2022 using a four-year transition period. Therefore, CY 2024 is the third year of the clinical pricing update. For CY 2024, we are finalizing one update to the cytotechnologist (L045A) clinical labor type in response to additional data submitted by commenters. In all other cases, the CY 2024 clinical labor rates differ slightly from the CY 2023 rates only in reflecting the third year of a 4-year transition to updated clinical labor rates.

- The impacts of the clinical labor rate update on PFS payments are largely driven by the share that labor costs represent of the direct PE inputs for each service. Specialties and services with a substantially lower or higher than average share of direct costs attributable to clinical labor will experience declines or increases, respectively.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

Evaluation and Management (E/M) Services (1)

O/O E/M Visit Inherent Complexity Add-On Code

- CMS finalized implementation of a separate add-on payment, beginning January 1, 2024, for healthcare common procedure coding system (HCPCS) code G2211.
- This add-on code will better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care
- Generally, it will be applicable for outpatient and office visits as an additional payment, recognizing the inherent costs involved when clinicians are the continuing focal point for all needed services, or are part of ongoing care related to a patient's single, serious condition or a complex condition.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

Evaluation and Management (E/M) Services (2)

Split or Shared Services

- Split (or shared) E/M visits refer to visits provided in part by physicians and in part by other nonphysician practitioners in hospitals and other institutional settings.
- For CY 2024, we finalized a revision to our definition of "substantive portion" of a split (or shared) visit to include the revisions to the Current Procedural Terminology (CPT) guidelines, such that for Medicare billing purposes, the "substantive portion" means more than half of the total time spent by the physician or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making.
- This responds to public comments asking that we allow either time or medical decision making to serve as the substantive portion of a split (or shared) visit.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Behavioral Health

- **Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)**
  - Finalized policies providing **Medicare Part B coverage and payment for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs)** when billed by these professionals.
  - Finalized policies to allow addiction counselors or drug and alcohol counselors who meet the applicable requirements to be an MHC to enroll in Medicare as MHCs.
- **Psychotherapy for Crisis Services**
  - Established **new HCPCS codes under the PFS for psychotherapy for crisis services** that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, **including the home or a mobile unit**) furnished on or after January 1, 2024.
  - Finalized the **payment amount for psychotherapy for crisis services equal to 150% of the fee schedule amount for non-facility sites of service** for each year for the services identified (as of January 1, 2022) by HCPCS codes 90839 (*Psychotherapy for crisis; first 60 minutes*) and 90840 (*Psychotherapy for crisis; each additional 30 minutes*

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Behavioral Health (2)

- **Other Behavioral Health Services**
  - We finalized policy to allow the Health Behavior Assessment and Intervention (HBAI) services described by **CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168**, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists.

  - We also finalized an **increase in the valuation for timed behavioral health services** under the PFS. Specifically, we finalized our proposal to apply an adjustment to the work RVUs for psychotherapy codes payable under the PFS, which we are implementing over a four-year transition.

  - In response to public comments, we also **finalized the application of this adjustment to psychotherapy codes that are billed with an E/M visit and to the HBAI codes**. We believe that these finalized changes will begin to address distortions that have occurred in valuing time-based behavioral health services over many years.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – MDPP Expanded Model

- **Medicare Diabetes Prevention Program (MDPP) Expanded Model**
  - CMS finalized changes to extend the MDPP Expanded Model's Public Health Emergency Flexibilities for four years, which will **allow all MDPP suppliers to continue to offer MDPP services virtually through December 31, 2027**
  - Suppliers must maintain an in-person Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) and utilize a new HCPCS G-Code for distance learning
  - CMS also finalized changes to simplify MDPP's current performance-based payment structure by **allowing fee-for-service payments for beneficiary attendance**

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Dental and Oral Health

- CMS codified previously **finalized payment policy for dental services for head and neck cancer treatments**, whether primary or metastatic
- CMS codified **Medicare Part A and Part B payment for dental or oral examination performed as part of a comprehensive workup** prior to medically necessary diagnostic and treatment services, to eliminate an oral or dental infection prior to, or contemporaneously with, those treatment services, and to address dental or oral complications after radiation, chemotherapy, and/or surgery when used in the treatment of head and neck cancer.
- CMS finalized **payment for certain dental services inextricably linked to other covered services** used to treat cancer prior to, or during:
  1. Chemotherapy services.
  2. Chimeric Antigen Receptor T- (CAR-T) Cell therapy.
  3. The use of high-dose bone modifying agents (antiresorptive therapy).

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Telehealth

- CMS is adding health and well-being coaching services to the Medicare Telehealth Services List on a temporary basis for CY 2024. We also finalized the addition of HCPCS code G0136 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) to the Medicare Telehealth Services List

- CMS finalized that **for 2024, claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the non-facility PFS rate**. We believe this policy will protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via Congressional legislation

- CMS removed frequency limitations for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation for 2024

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Telehealth (2)

- CMS finalized the **continuation of our revised direct supervision policy to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024**
- Additionally, **we also extended PHE flexibilities to allow practitioners furnishing telehealth services from their homes to report their office addresses on their enrollment forms**. This extension aligns with telehealth-related flexibilities that were previously extended and **addresses practitioner privacy and safety concerns** about including their home addresses as practice locations on their enrollment forms.

Telehealth Services Furnished in Teaching Settings

- CMS finalized a policy to allow **teaching physicians in all training settings to be present using audio/video real-time communications technology when a resident is providing Medicare telehealth services** consistent with other applicable telehealth policies. This virtual presence would meet the requirement that the teaching physician can bill under the PFS for the service involving the resident if they are present for the key portion of the service. The virtual presence policy applies in all teaching settings through December 31, 2024.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Health Equity

Caregiver Support

- For CY 2024, CMS will make payment when practitioners train caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan.

- Medicare will pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) as part of the patient's individualized treatment plan or therapy plan of care.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Health Equity (2)

Social Determinants of Health (SDOH) Risk Assessment

- We finalized coding and payment for SDOH risk assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient.

- We are finalizing the addition of the SDOH risk assessment to the annual wellness visit as an optional, additional element with an additional payment and no patient coinsurance nor deductible (when provided with the annual wellness visit).

- We also finalized codes and payment for SDOH risk assessments furnished with an evaluation and management or behavioral health visit.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Health Equity (3)

Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

- For CY 2024, we finalized **specific coding and payment** for monthly community health integration and principal illness navigation services to account for **when clinicians involve auxiliary personnel such as community health workers and care navigators to support patients who have unmet SDOH needs** that affect the diagnosis and treatment of their medical problems and when certain patients with high-risk conditions need assistance connecting with appropriate clinical and other resources.
  - We also finalized a new set of additional PIN codes that practitioners may bill when specifically supervising auxiliary personnel such as peer support specialists to support patients with behavioral health conditions that meet the qualifications of a serious, high-risk illness as outlined in PIN.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Quality Payment Program

Quality Payment Program (QPP) Policy Updates:

- MIPS Value Pathways (MVPs)
- Traditional Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)
- Public Reporting
- Medicare Shared Savings Program (Shared Savings Program)

QPP 2024 Final Rule Resources Zip File Resources

2024 Physician Fee Schedule – Quality Payment Program (2)

CMS finalized **5 new MVPs** and revised **all previously established MVPs** that will be available beginning with the 2024 performance year:

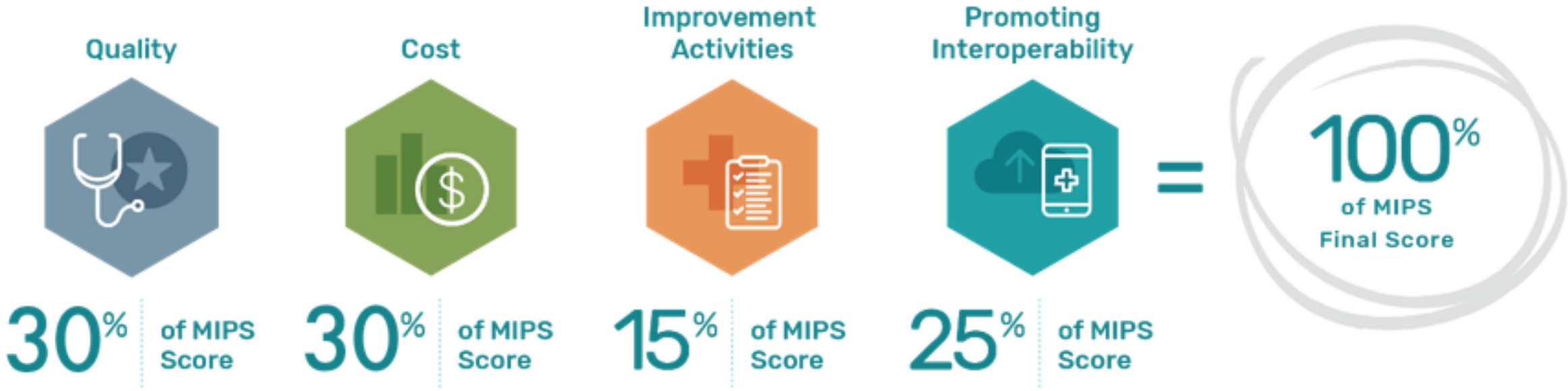
Newly Finalized MVPs
Focusing on Women's Health
Quality Care for the Treatment of Ear, Nose, and Throat Disorders
Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
Quality Care in Mental Health and Substance Use Disorders
Rehabilitative Support for Musculoskeletal Care

Previously Established MVPs
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
Advancing Cancer Care
Advancing Care for Heart Disease
Advancing Rheumatology Patient Care
Coordinating Stroke Care To Promote Prevention and Cultivate Positive Outcomes
Improving Care for Lower Extremity Joint Repair
Optimal Care for Kidney Health
Optimal Care for Patients with Episodic Neurological Conditions
Patient Safety and Support of Positive Experiences with Anesthesia
Value in Primary Care*
Supportive Care for Neurodegenerative Conditions

* This new MVP title reflects consolidation of previously existing MVPs: Optimizing Chronic Disease Management and Promoting Wellness

https://qpp.cms.gov/mips/explore-mips-value-pathways

MIPS 2024 Performance Categories



- Comprised of **4** performance categories.
- The points from each performance category are added together to give you a MIPS final score.
- The MIPS final score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

2024 Physician Fee Schedule – Quality Payment Program (4)

Visit the QPP Resource Library for:

- Overview Fact Sheet and Policy Comparison Table
- QPP Final Rule MVPs Guide
- FAQs

CY 2024 PFS Final Rule posted here: https://www.federalregister.gov/public-inspection/2023-24184/medicare-and-medicaid-programs-calendar-year-2024-payment-policies-under-the-physician-fee-schedule

QPP 2024 Final Rule Resources Zip File Resources

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